

Remarks of
HENRY A. WAXMAN, CHAIRMAN
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
before the
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
May 15, 1990

Thank you for inviting me to join you this morning.

Last November, as part of the budget reconciliation package, Congress enacted two major initiatives: Medicare physician payment reform, and a Federal program for outcomes research and the development of clinical practice guidelines.

I want to talk with you today about these two initiatives, and about the prospects for budget reconciliation this year. Then I'd like to close with some thoughts about access to health care for the uninsured.

Medicare

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Last year saw the culmination of several years' work on RB RVS payment reform in Medicare.

It's obvious that these reforms will significantly change the environment within which physicians practice medicine. There will be changes in the methods for payment. There will be changes in the amounts of payment. And Medicare will begin to focus more intently on what it is paying for, and under what condition services are being furnished.

As we move to a system of administered prices, Medicare will have to be more careful in defining what is included in, or excluded from, the service for which the price has been established.

As a result of the RB-RVS reform, some physicians will receive lower revenues from Medicare, while other physicians will receive more. But all physicians will be more closely monitored by Medicare in how they practice medicine.

I supported both the RB RVS payment reform and the development of clinical practice guidelines and medical review criteria. But I continue to have serious misgivings about the so-called "volume performance standards," which were adopted at the insistence of the Bush Administration.

As you know, these are targets for the total expenditures for physician services under Medicare for a twelve month period. If total expenditures exceed the target, then the annual update in physician fees two years later is supposed to be reduced accordingly. The target for this year has been set at 9.1 percent. It is almost certain to be exceeded, and two years from now payments will be reduced accordingly. The Secretary's recommended target for 1991 is 9.9 percent.

My concern is that we have put the cart before the horse. We have established the target, retroactively, before the physician community has the tools to monitor itself and work cooperatively to reduce the rate of increase. Physicians who are delivering appropriate care will face the same financial penalty as those who are abusing the program, yet there is little that the responsible physicians can do to protect themselves.

Volume performance standards are irrational and unfair. But the budgetary reality is that they will be with us so long as the rates of increase in Medicare expenditures continue to exceed 10 percent each year.

Looking at the Subcommittee's agenda this year, I do not expect any Medicare legislation of comparable scope. Instead, we will be monitoring the implementation of payment reform and the development of clinical practice guidelines.

BUDGET

Unfortunately it also appears we have to make further cuts in Medicare. The only real issue is how large those cuts will be.

The House Budget committee Fiscal 1991 budget adopted a relatively moderate approach -- it assumed that we will lower Medicare outlays by \$1.7 billion next year. This is far less than the \$5.5 billion in cuts that the Bush Administration has suggested. The House target was selected to coincide with the projected cut that would occur in Medicare if the Gramm-Rudman reductions were allowed to take place. This target was the result of weeks of discussion where larger cuts were considered and rejected, primarily because of the vocal -- and, I might add, virtually unanimous -- opposition of the members of my own Subcommittee and the health subcommittee of Ways and Means. Not to mention the concern expressed by many members of the House that years of cuts were taking their toll on health care providers in their districts.

By all reports, the Senate budget committee has recommended a slightly higher figure than the House, assuming first year cuts of \$2 billion. Unfortunately, the out-year targets in the Senate are reported to grow very rapidly, so there is cause for concern.

And the news may well get worse. It now appears that the budget deficit is even larger than estimated earlier in the year, and as a result, we are starting a new round of budget negotiations with the White House, with -- quote, "no preconditions." There are many new issues now on the table, and it's anybody's guess where things will come out. I think we can predict continued Administration pressure for deep Medicare cuts, but I'm hopeful that the House and Senate's stand on the Medicare budget will continue to prevail. We will need your help, though, if there is to be any hope of success.

Whatever the final outcome, I am going to make every effort to assure that the Medicare cuts we are forced to enact will not undermine payment reform.

PRESIDENT'S BUDGET

Let's go back to what we might expect the Administration to put on the table at these deficit-reduction talks. To find out, we need look no further than the President's original proposal which, as I noted, contains Medicare reductions of \$5.5 billion in 1991. His proposals include reduced payments for hospital services, lower fees for physician services, and reductions in both coverage

Will these proposals improve the effectiveness of the Medicare program? No. Their main purpose is deficit reduction. And their effect is to jeopardize the availability and quality of health care for our nation's elderly and disabled.

We should think very carefully before we extend the types of freezes and reductions we have been churning out over the last several years, since we have so little reliable information about their effects on access and quality of care so far.

Included among the President's proposals are several that would reduce payments under Medicare for anesthesiologists, including a 10 percent reduction, on average, in fees and reductions in payments for the supervision of nurse anesthetists (eqqa-nes'-the-tists). I think we have to scrutinize such proposals very carefully.

I understand that payments for anesthesia will be reduced, in most cases, under the RB-RVS reform -- sometimes by a substantial amount. I also recognize -- indeed, I have promoted -- a strategy of anticipating the results of the RB-RVS reform and beginning the transition before its official start date in 1992. Thus, I have no overriding objection to the basic concepts put forth by the Administration.

Nonetheless, I have also urged that we not make very large changes in an abrupt fashion. People need time to adjust to major changes and to understand their implications. In addition, we need time to monitor the effects of major changes and determine whether mid-course corrections are needed in order to preserve access and quality.

We have had a cooperative and productive working relationship in the past on such matters and I am sure it will continue.

MORE MEDICARE

There are some other Medicare issues on the Subcommittee agenda. We are hearing more and more concern being expressed about how the Medicare program affects patients and physicians. Issues are being raised regarding quality of care, utilization review, and other administrative requirements.

The Institute of Medicine has recently released an important study, requested by Congress, which proposes major changes in the quality assurance for the Medicare program. I expect that our Subcommittee will want to explore this in some detail.

Last month, the Subcommittee held a hearing in Atlanta which highlighted some of the concerns about the administration of the Part B program by the carriers, particularly medical and utilization review. This will continue to receive the attention of the Subcommittee.

Outcomes Research/Clinical Practice Guidelines

I believe the RB RVS payment reforms will improve the mix of services provided to Medicare patients. But even more important in this respect will be the work of the new Agency of Health Care Policy and Research. The major focus of the new agency is to conduct and support research on the most effective way of diagnosing and treating various patient conditions. It has a broader charter and significantly greater resources than was previously available for health services research and technology assessment.

The work of this new agency is to focus on clinical practice, with one of its highest priorities being primary care and practice-oriented research. And I believe the work of this agency will, in the long run, have a more important influence on the delivery of health care than the various payment reforms we have been enacting.

Health Care for the Uninsured

Finally, let me turn to the issue of the uninsured. We have over 31 million citizens who have no public or private insurance coverage. And the Census Bureau recently reported that 63 million Americans went without health insurance coverage sometime during a 28 month period. That's almost 30 percent of our population!

Last month, the Pepper Commission recommended a \$23 billion program to extend basic health care coverage to the uninsured, using a combination of employer-based insurance and a new public program for those without employer coverage. The Commission also proposed a \$34 billion long-term care program.

I was a member of the Pepper Commission and I support its recommendations. They are not perfect. I had hoped that the cost containment provisions would be stronger, and that the States could be relieved of their current financial responsibility for acute care services under the public program.

But the Commission's recommendations will frame the Congressional debate on the uninsured. I believe that they are not just a starting point for discussion, but that they are a blueprint for what the Congress will ultimately legislate in this area. There is little support in the Congress for a Canadian-style approach, and there is increasing impatience with the status quo. The only viable alternative is to start with what we have -- an employer-based, privately administered insurance system -- and build upon that.

The problem now is leadership. Those with the responsibility to lead -- President Bush and his Administration -- have run for cover behind study commissions. The Chairman of the Pepper Commission, Senator Rockefeller, is doing all that he can to develop a consensus in the Congress around the Commission's recommendations. But he cannot make up for the leadership failure in the White House.

Conclusion

From maintaining and improving the integrity of the Medicare program, to providing access to quality health care for all Americans, the Congress has many challenges before it in the area of health. I appreciate the support we have received from your organization, and look forward to working with you in the future. It is important that we continue to dedicate ourselves to the programs that will lead us to a healthier America.